CARIBBEAN

HIV and AIDS statistics and features, in 2003 and 2005

	Adults and children living with HIV	Number of women living with HIV	Adults and children newly infected with HIV	Adult prevalence (%) *	Adult and child deaths due to AIDS
2005	300 000 [200 000 – 510 000]	140 000 [88 000–250 000]	30 000 [17 000–71 000]	1.6 [1.1–2.7]	24 000 [16 000–40 000]
2003	300 000 [200 000–510 000]	140 000 [87 000–250 000]	29 000 [17 000–68 000]	1.6 [1.1–2.7]	24 000 [16 000–40 000]

The AIDS epidemic claimed an estimated 24 000 [16 000–40 000] lives in the Caribbean in 2005, making it the leading cause of death among adults aged 15–44 years. A total of 300 000 [200 000–510 000] people are living with HIV in the Caribbean, including the 30 000 [17 000–71 000] people who became infected in 2005. In the Caribbean Community (CARICOM) region 240 000 [150 000–450 000] people are living with HIV, including the 25 000 [12 000–65 000] people who acquired the virus in 2005. More than 20 000 [13 000–36 000] people died of AIDS in the past year in this region.[1]

The Caribbean's status as the second-most affected region in the world masks substantial differences in the extent and intensity of its epidemics. Estimated national adult HIV prevalence surpasses 1% in **Barbados**, **Dominican Republic**, **Jamaica** and **Suriname**, 2% in the **Bahamas**, **Guyana** and **Trinidad and Tobago**, and exceeds 3% in **Haiti**. In **Cuba**, on the other hand, prevalence is yet to reach 0.2%.

While a few countries have made progress in monitoring and dealing with their epidemics, inadequate HIV surveillance hampers a detailed understanding of recent epidemiological trends in some countries. Unfortunately, this applies also to countries which, in the past, have recorded alarming levels of HIV infection among pregnant women, including **Bahamas** and **French Guiana**. The reasons for such shortcomings include resource constraints but reluctance among public officials to publicize the scale of their AIDS epidemics might be a factor as well.

The region's epidemics are driven primarily by heterosexual intercourse (the documented mode of transmission in three quarters or more of all AIDS cases reported to date), with commercial sex a prominent factor, against a backdrop of severe poverty, high unemployment and gender inequalities. In-depth research on the interplay between the sex industry and HIV transmission, however, remains comparatively limited in the Caribbean. Even more infrequent is acknowledgement of the significant role sex between men plays in many Caribbean countries' epidemics. The overall share of reported HIV infections attributed to sex between men is approximately 12%, but homophobia and robust sociocultural taboos that stigmatize same sex

[1] CARICOM comprises: Antigua and Barbuda, the Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Haiti, Jamaica, Montserrat, Saint Lucia, St. Kitts and Nevis, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago.

relations mean that the actual proportion could be somewhat larger (Inciardi et al., 2005). Injecting drug use is responsible for a small minority of HIV infections currently; only in **Bermuda** and **Puerto Rico** does it contribute significantly to the spread of HIV.

New HIV infections among women are surpassing those among men. Young women in particular face considerably higher odds of becoming infected than do young men. In **Trinidad and Tobago**, for example, HIV infection levels are six times higher among 15–19 year-old females than among males of the same age (Inciardi et al., 2005). Earlier studies indicated that women younger than 24 years in the **Dominican Republic** were almost twice as likely, and teenage girls in **Jamaica** were two-and-a-half times more likely to be HIV-infected, compared with their male counterparts (MAP, 2003). Girls' and young women's physiological susceptibility to infection partly accounts for such discrepancies, but also important is the relatively common practice of younger women establishing relationships with older men (who, by virtue of their age, are more likely to have acquired HIV). In some countries, sexual activity begins comparatively early—when surveyed, one quarter of 15–29 year-old women in **Barbados** said they had been sexually active by the time they turned 15. And almost one third of men aged 15–29 years reported multiple sexual partnerships in the previous year, according to the same survey (Caribbean Technical Expert Group, 2004). Such trends are likely to provide the epidemic with momentum.

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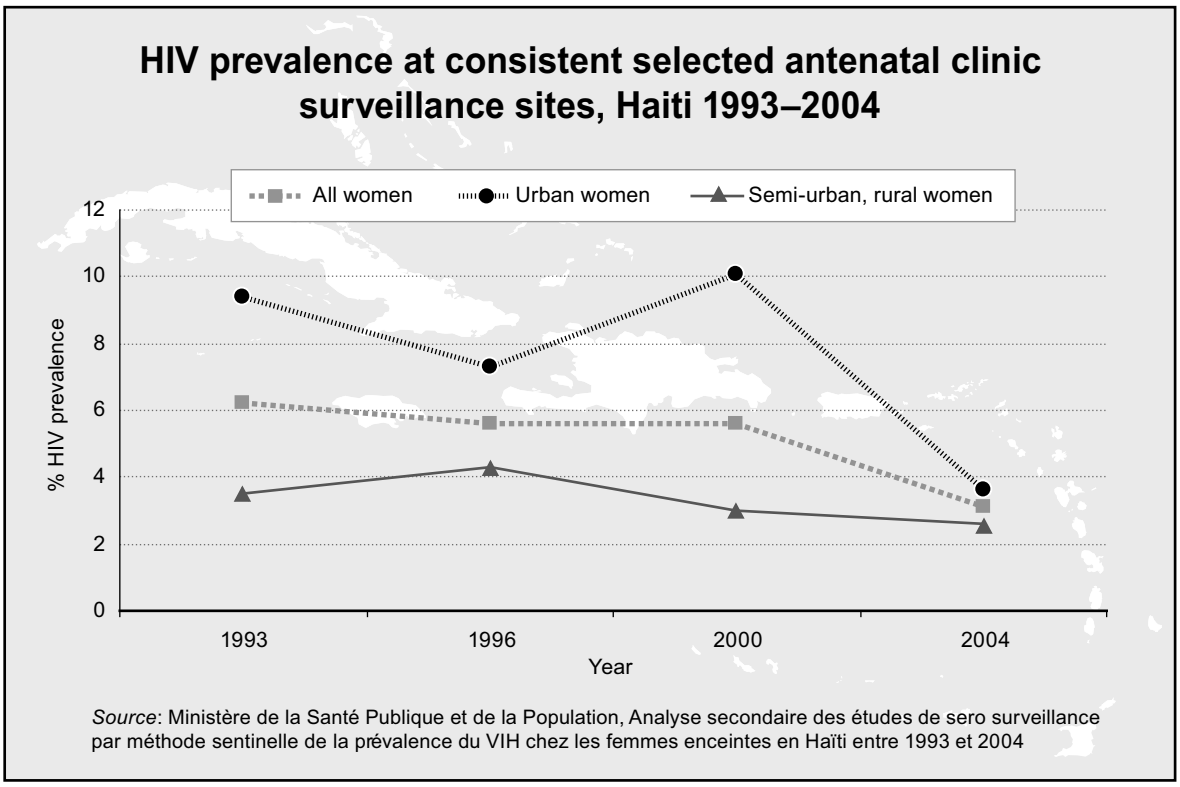
At the same time, several recent developments in the Caribbean give cause for guarded optimism. **Haiti's** epidemic, one of the oldest in the world, could be turning a corner. Overall, the percentage of pregnant women testing HIV-positive reduced by half from 1993 to 2003-2004

Figure 17



Source: Ministère de la Santé Publique et de la Population, Analyse secondaire des études de sero surveillance par méthode sentinelle de la prévalence du VIH chez les femmes enceintes en Haïti entre 1993 et 2004

Is Haiti turning a corner?

HIV prevalence among pregnant women in Haiti generally has decreased since the mid-1990s, but the trends in urban and rural parts of the country have shown distinct differences. Data from five sentinel sites (distributed across the country) with comparable data from 1993 to 2003-2004 show HIV prevalence dropping steeply from 9% to 3.7% among urban women. Data for 1996 to 2003-2004 from a further nine sites also show a pronounced decline in HIV infection levels among urban women, from 8% to 4% (Gaillard et al., 2004b). This suggests that HIV prevalence in urban areas possibly peaked in the mid-1990s before gradually declining. However, among semi-urban and rural women, the changes are much less evident. For them, HIV prevalence at the five sites with comparable data was only slightly lower in 2003-2004 compared with 1993 (2.6% versus 3.5%).

What might account for these trends? On the one hand, a significant proportion of Haitians has reported changing their sexual behaviour. In 2000, almost twice as many men and women said they were abstaining from sex, for example, compared with 1994 (11% versus just under 7%). In addition, more people said they were remaining with one partner (45% of men and 32% of women in 2000, compared to 37% and 20%, respectively, in 1994).

On the other hand, there is evidence of behaviour change that could signal greater risk of HIV transmission. For example, young Haitians are becoming sexually active at earlier ages. Median ages at first sex was 19.8 years for men and 18.3 years for women in 1994; six years later, the ages were 18.2 years for men and 17.5 years for women (Gaillard et al., 2004b). Correspondingly, the percentage of 15–19 year-olds who say they have never had sex decreased to 66% for women and 48% for men in that age group (compared to 71% and 53%, respectively, in 1994) (Gaillard et al, 2004b). Condom use among young Haitians (15–24 years) has also decreased. Just 28% of young Haitian women (15–24 years) in 2003 said they had used a condom the last time they had sex, as did 37% of men of the same age. It might be that older Haitians have been taking greater precautions to avoid HIV infection. The declines in HIV prevalence appear to be more pronounced among women older than 24 years of age.

However, AIDS mortality very likely accounts for a substantial share of the observed drop in infection levels. If AIDS deaths are helping drive HIV prevalence lower, the comparatively slight decline in infections levels seen in *rural* areas could imply that HIV incidence there is still marked. In that case, considerable numbers of people would be acquiring HIV while AIDS also kills large numbers of people—causing the overall number of people living with HIV to stay stable or decline slightly. In addition, the sociopolitical upheavals of recent years could be generating conditions (such as displacement, social instability and livelihood insecurity) that allow for more rapid spread of HIV. There is no guarantee, therefore, that the decrease in HIV prevalence observed in urban areas will continue or extend into rural areas without strong, sustained HIV prevention programmes. Such efforts should take account of the fact that HIV prevalence among pregnant women varies considerably (ranging from 1.8% to almost 7% in different parts) (Ministère de la santé publique et de la population Haïti et al., 2004).

(from 6.2% to 3.1%). The trend has been most pronounced in urban areas (where HIV prevalence fell from 9.4% in 1993 to 3.7% in 2003-2004), and especially among 15–24 year-olds—which suggests that a significant slowing down of new HIV infections could be occurring in the country's cities (Gaillard et al., 2004b). The decline appears to be associated with some behavioural change. AIDS mortality is almost certainly an important contributing factor (see box). In rural areas, the decline has been much more modest. Since Haiti still has the largest number of people living with HIV in the Caribbean (an estimated 173 000 in 2004) (Gaillard et al., 2004a), intensification of HIV prevention is imperative in the country.

Sharing the island of Hispaniola with Haiti is the **Dominican Republic**, which appears also to be seeing some rewards as a result of its AIDS response. HIV infections levels in pregnant women have been declining since the late 1990s, with overall HIV prevalence in pregnant women roughly stable at the 1.4% measured in the 2004 round of sentinel surveillance. However, in some sites (such as San Juan de la Maguana)

HIV prevalence at antenatal clinics was 2.7% (Secretaria de Estado de Salud Pública y Asistencia Social de Republica Dominica, 2005b). In the capital Santo Domingo, HIV prevalence among pregnant women was 1.3% at the main antenatal clinic in 2004, a significant change from the over 2% found in 1995 (Secretaria de Estado de Salud Pública y Asistencia Social de Republica Dominica, 2005b; UNAIDS/WHO, 2004). However, HIV infection levels among pregnant women are considerably higher in other parts of the country: 2.3% in San Juan, in the west, and 2.5% in La Romana, in the east, for example. And in some bateyes (the impoverished communities of mainly Haitian workers that service sugar cane mills), infection levels of 5.5% in men and 4.7% among women have been found.

Low HIV infection levels of 3–4% found among sex workers in Santo Domingo probably reflect efforts to encourage consistent condom use and other safer behaviours in their ranks. When surveyed in the capital, 87% of sex workers reported using a condom the last time they had sold sex, and 76% said they always used a condom during paid sex (Ministerio de Salud de Republica Dominica, 2005a). As in other Caribbean countries, sex between men seems to be playing a significant, though inadequately recognized role in the Dominican Republic's epidemic. A recent study in three cities (Puerto Plata, Samana and Santo Domingo) among men who have sex with men found 11% of them were living with HIV (Toro-Alfonso and Varas-Diaz, 2004) In another study, about one third of men who have sex with men said they had also slept with women in the previous six months—and only half of them said they had used a condom during that period.

HIV-infection levels have declined in the Bahamas, indicating that improved HIV prevention efforts could be responsible for part of that trend. Newly reported HIV infections decreased from 409 in 2000 to 275 in 2003 (a 32% decline), while HIV prevalence measured in pregnant women followed a similar path, (dropping from 4.8% in 1993 to 3% in 2002); HIV levels among patients at sexually transmitted infection clinics also fell (Caribbean Technical Expert Group, 2004; Department of Public Health The Bahamas, 2004). Enhanced clinical management and treatment of AIDS at the community level has drastically reduced mother-to-child transmission of HIV. It has likely also contributed to the declining number of annual deaths attributable to AIDS in the country (from 272 in 2000 to 185 in 2003) (Caribbean Epidemiology Centre, PAHO, WHO, 2003). It is estimated that at least 30% of persons with HIV were receiving appropriate clinical management at community clinics in 2003.

Stepped-up efforts to confront the smaller epidemic in **Barbados** also appear to be paying dividends. New HIV diagnoses among pregnant women decreased by half between 1999 and 2003 (with prevalence slipping from 0.7% to 0.3%) (Kumar and Singh, 2004), while the expansion of voluntary counselling and testing services, and provision of antiretroviral prevention regimens has reduced mother-to-child transmission of HIV (St John et al., 2003). Wider access to antiretroviral treatment cut AIDS deaths by half in 1998–2003, a trend also witnessed in **Bermuda** in 2000–2002 (Caribbean Epidemiology Centre, 2004; Caribbean Epidemiology Centre, PAHO, WHO, 2003).

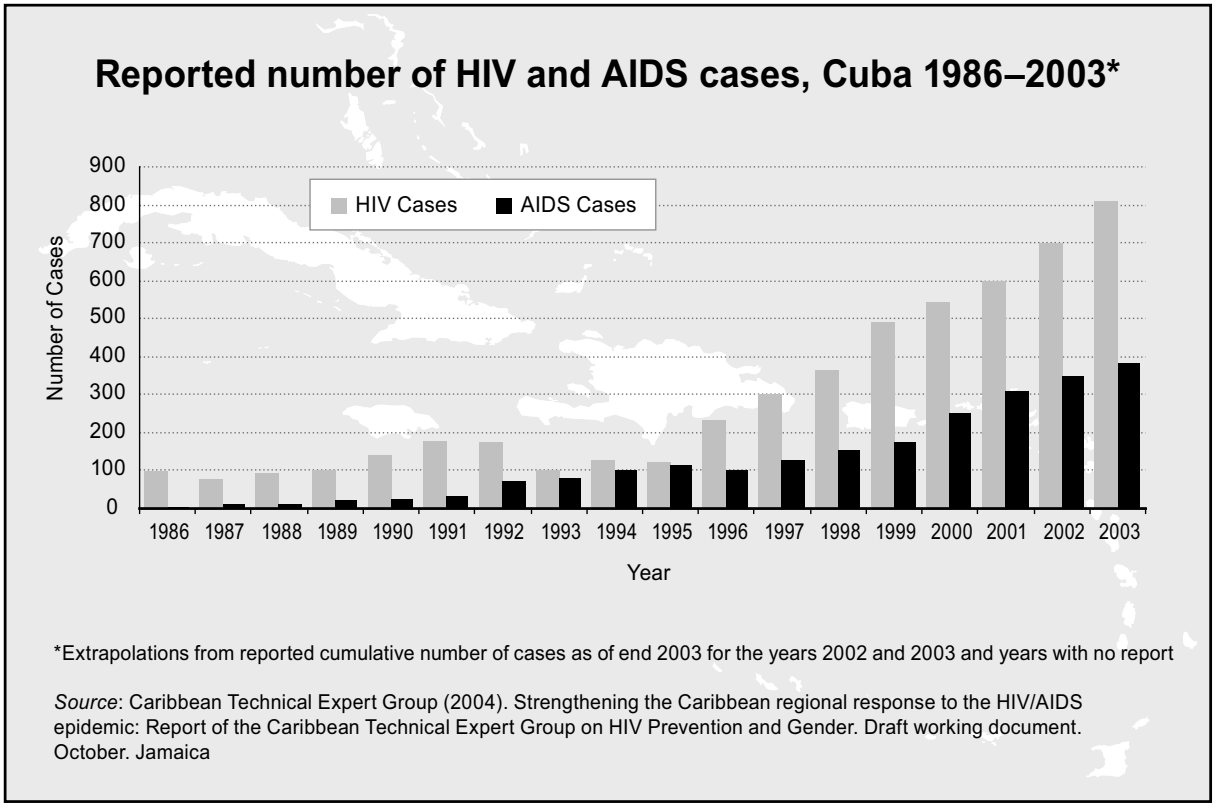
In **Jamaica**, most HIV infections are occurring in urban areas, with the parishes of Kingston, St. Andrew, and St. James worst-affected. HIV prevalence among pregnant women has remained at 1–2% since the mid-1990s, although recent HIV surveillance at antenatal clinics suggests that prevalence might be declining slightly in parts of the country (the parishes of St. Ann and St. James, for example) (Ministry of Health Jamaica, 2004). There are some signs that a large proportion of Jamaicans take precautions to protect themselves against HIV infection. In surveys over the past decade, about three quarters of men have said they used a condom the last time they had sex with a casual partner. The percentage of women reporting the same behaviour almost doubled from 1992–2000 (Caribbean Technical Expert Group, 2004). As in Jamaica, unprotected heterosexual intercourse is the driving factor in the epidemic in **Trinidad and Tobago**, where estimated national adult HIV prevalence edged past 3% in 2003. A recently-published study among women giving

birth in Tobago found 2.6% of them were HIV-positive; among those younger than 25 years, prevalence was 3.8%. A very large percentage of women were also infected with HSV2, a sexually transmitted infection which, as studies in Africa have shown, greatly enhances the risk of HIV transmission (Duke et al., 2004; Weis et al., 2001).

Guyana and **Suriname** are experiencing serious epidemics. National HIV prevalence in **Guyana** was estimated at 2.5% at the end of 2003, and AIDS has become the leading cause of death for people aged 25–44 years (UNAIDS/WHO, 2004). The steep rise in officially-reported HIV cases reported over the past decade suggests a worsening epidemic, with high HIV prevalence having been recorded among men and women attending sexually transmitted infection clinics (15% for men and 12% for women in 2002) (Caribbean Technical Expert Group, 2004). However, HIV information is limited outside the country's cities, making it difficult to gauge the actual extent of the epidemic.

Just under 2% of adult Surinamese were living with HIV at the end of 2003. New registered HIV cases have increased threefold since the mid-1990s (104 in 1996 to 371 in 2003), but much of that trend is probably due to increased testing. High levels of HIV infection found in men who have sex with men (7% in a 2005 study) indicate that sex between men features in Suriname's epidemic; previous research indicated that about one third of men who have sex with men also had sexual relationships with women (CAREC/PAHO, 2005b; Del Prado et al., 1998). HIV knowledge appears to be high among men who have sex with men (about 80% of the men knew at least three ways of protecting themselves against infection). Although 70% of the men said they always used a condom during commercial sex, another study found that more than one in three male sex workers were HIV-positive (CAREC/PAHO, 2005a and 2005b). Given that among female sex workers HIV prevalence is also very high (21%, according to a 2005 study), commercial sex work likely plays a central role in Suriname's epidemic (CAREC/PAHO, 2005b).

Figure 18



*Extrapolations from reported cumulative number of cases as of end 2003 for the years 2002 and 2003 and years with no report

Source: Caribbean Technical Expert Group (2004). Strengthening the Caribbean regional response to the HIV/AIDS epidemic: Report of the Caribbean Technical Expert Group on HIV Prevention and Gender. Draft working document. October. Jamaica

Cuba's epidemic remains by far the smallest in the Caribbean, with adult HIV prevalence estimated to be less than 0.1% (Caribbean Technical Expert Group, 2004). However, new HIV infections are on the rise, and Cuba's preventive measures appear not to be keeping pace with conditions that favour HIV spread, including widening income inequalities and a growing sex industry (Camara et al., 2003; Inciardi et al., 2005). At the same time, Cuba's prevention of mother-to-child transmission programme remains highly effective. All pregnant women are tested for HIV, and those testing positive receive antiretroviral drugs. As a result of this policy and overall low infection rates, fewer than 20 HIV-infected babies had been born by 2004 (Susman, 2003; Caribbean Technical Expert Group (2004). In addition, universal, free access to antiretroviral therapy has kept the number of AIDS cases and deaths low.

Improved HIV and behavioural surveillance is essential if effective prevention strategies are to be achieved and sustained in the Caribbean. Lacking in particular is reliable, up-to-date information about behaviour patterns and trends among at-risk sections of the population such as sex workers and men who have sex with men, and the ways in which the behaviours might feature in HIV transmission. The continuing shortage of good quality HIV surveillance data stands in the way of potentially effective HIV prevention programmes and will hinder the effectiveness of the antiretroviral treatment roll-outs, which remain highly uneven in this region. While universal treatment access is being achieved in Cuba, and coverage is relatively high in the **Bahamas** and **Barbados**, access to treatment is poor in three of the worst-affected countries in the Caribbean. About one third of people in need of antiretroviral treatment were receiving it in **Trinidad and Tobago** in September 2005, as were a mere 12% in **Haiti** and 10% in the **Dominican Republic** (PAHO, 2005).